PAYMENTS TO FQHCS (Federally Qualified Health Care Centers) / RHCS (Rural Health Clinics)/ FQHC Look-alike Health Care Centers

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I. Purpose

This policy outlines the procedures necessary to calculate the quarterly supplemental payments to be paid to Federally Qualified Health Care Centers (FQHCs) and Rural Health Clinics (RHCs) that subcontract (either directly or indirectly) to provide covered services to Medicaid enrollees with a Managed Care Entity (MCE), as well as the annual reconciliation process. The quarterly supplemental payment and annual reconciliation process excludes Title XXI, Federal Emergency Services, Social Security Disability Insurance-Temporary Medical Coverage and Healthcare Group members.

Under the Benefits Improvement and Protection Act of 2000 (BIPA), AHCCCS is required to reimburse FQHCs/RHCs the difference between the MCE's reimbursement to the FQHC/RHC, and what the FQHC/RHC would have received under the BIPA Medicaid Prospective Payment System (PPS) or the Alternative Payment Methodology, no less frequently than every four months.

As a result of the PPS Annual Reconciliation described below, AHCCCS estimates the difference between the MCE's reimbursement to the FQHC/RHC and what the FQHC/RHC would have been paid under the Medicaid PPS annually. AHCCCS then computes a new annual per member per month (PMPM) supplemental payment rate to calculate the subsequent quarterly supplemental payment amounts to the FQHC/RHC based on member months reported quarterly by the MCE as described below.

II. Definitions

Federally Qualified Health Care Centers (FQHCs) – FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it: (i) receives a grant and funding pursuant to Section 330 of the Public Health Service Act; (ii) is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act; (iii) is determined by the Secretary of DHHS to meet the requirements for receiving such a grant (look-alike) based on the recommendation of HRSA within PHS; or, (iv) was treated by the Secretary of the Department of Health and Human Services (DHHS) as a Federally Funded Health Center (FFHC) for purposes of Part B Medicare as of January 1, 1990. An FQHC includes an outpatient program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

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FQHC Look-Alike - An FQHC Look-Alike is an organization that meets all of other eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.

Managed Care Entities - Acute Care Health Plans, Arizona Long Term Care System Elderly and Physically Disabled Program Contractors, Department of Economic Services Department of Developmental Disabilities and Comprehensive Medical and Dental Program (CMDP).

Rural Health Clinics (RHCs) – RHCs are clinics located in areas designated by the Bureau of Census as rural and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians and meets the requirements under 42 CFR 491.

Reimbursement – Cash receipts collected for health care services performed on a fee for service basis including capitation (a fixed amount of money per member per unit of time paid in advance for the delivery of health care services). Note: The annual reconciliation is completed based on the federal fiscal year (October 1st to September 30th); however Attachment 3 requests the detail for both the FQHC/RHC fiscal year and the federal fiscal year for purposes of completing the annual reconciliation and setting/rebasing rates.

Title XIX Member - Member eligible for Federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver Groups, Medicare Cost Sharing Groups, Breast and Cervical Cancer Treatment program and Freedom to Work Program.

Title XIX Waiver Group - All MED (Medical Expense Deduction) members, and adults or childless couples at or below 100% of the Federal Poverty Level who are not categorically linked to another Title XIX program. This would also include Title XIX linked individuals whose income exceeds the limits of the categorical program.

Visit - A face to face encounter between a patient and a health professional -

- a physician,
- a dentist or oral surgeon,
- a dental hygienist (when services are billed under the dentist's license number),
- a physician assistant,
- a nurse practitioner,
- a nurse midwife,
- a home health and visiting nurse, (to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there exists a shortage of home health agencies),

- a registered dietician (pursuant to a referral by a physician and as defined in section 1861 subsection (r)(1) of the Social Security Act),
- a clinical psychologist, or
- a clinical social worker,

during which an AHCCCS covered service (as specified in Title 9, Chapter 22, Article 2 and Title 9, Chapter 28, Article 2 of the Arizona Administrative Code is rendered. . Visits with more than one health professional within the same discipline (e.g. medical, dental and behavioral health for a maximum of three visits) and multiple visits with the same health professional which take place on the same day and at a single location, constitute a single visit, except for cases in which the patient, subsequent to the first visit, suffers an illness or injury requiring additional diagnosis or treatment. For purposes of the annual reconciliation, only those visits associated with Title XIX eligible members enrolled in a Managed Care Entity should be counted. Title XXI, Federal Emergency Services, Social Security Disability Insurance-Temporary Medical Coverage, Healthcare Group members and any State only populations are excluded from the annual reconciliation.

Site of Services -AHCCCS is required to follow Federal guidelines as set forth in 42 CFR Ch IV. In accordance with those guidelines, place of service is defined under Section 405.2446 Scope of Services. Subparagraph (1)(c) defines the site of service to be "when provided in outpatient settings only, including a patient's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a patient's home". Subparagraph (1)(d) further states: "Federally qualified health center services are not covered in a hospital, as defined in section 1861(e)(1) of the Act."

III. Policy

A. Calculation of FQHC/RHC Quarterly PMPM Supplemental Rate

1. FQHCs/RHCs that provide services under a contract with a MCE and are AHCCCS registered providers will receive quarterly supplemental payments, for the cost of furnishing covered services that are an estimate of the difference between the reimbursement the FQHC/RHC receives from the MCEs and the amount the FQHC/RHC would have received if the MCE paid the per visit rate as calculated under the BIPA PPS or Alternative Payment methodologies.

2. The quarterly supplemental PMPM rate is calculated annually based on the adjusted PPS rate per visit (adjusted for any scope of service changes and then inflating the adjusted PPS rate using the Medicare Economic Index (MEI), or the Physician Services Index (PSI) of the Consumer Price Index (CPI) for those FQHCs/RHCs selecting the Alternative Payment Methodology.) The inflated rate is then used to calculate the estimated settlement using the number of visits and MCE reimbursement provided by the FQHCs/RHCs for the annual reconciliation. (See Attachment 1)

B. PPS Annual Reconciliation

1. At the end of each federal fiscal year, the total amount of the AHCCCS quarterly supplemental payments and the MCE reimbursements received by each FQHC/RHC will be reconciled against the calculated amount that the actual number of visits furnished by the FQHC/RHC pursuant to their contracts with the MCEs would have yielded under the PPS or Alternative Payment Methodology. A request will be sent to the FQHCs/RHCs no later than January 30th of each year to provide visits and reimbursement data as supporting documentation for the annual reconciliation including:
   a. a copy of the annual audit report;
   b. an annual schedule of visits and reimbursements comprised of three time periods that cover both the federal fiscal year and the FQHC's/RHC's fiscal year (See Attachment 3), with supporting schedules for the visits from the FQHC's/RHC's practice management system;
   c. a schedule of supplemental payments received from AHCCCS;
   d. a copy of the annual Medicare filing package (cost report, trial balance, crosswalk and HCFA 339 report); and,
   e. a copy of the annual Uniform Data System (UDS) report.

   The difference between the PPS amount calculated using the actual number of visits and the total amount of AHCCCS supplemental payments and reimbursement received from the MCEs by the FQHC/RHC for Title XIX members, will be paid/(recouped) to/(from) the FQHC/RHC. If the FQHC/RHC cannot provide detail

for the KIDSCARE (Title XXI) visits and reimbursements, AHCCCS will adjust for KIDSCARE using the total KIDSCARE enrollment as a percentage of total enrollment. (See Attachment 1)

2. The reconciliation will be completed within 90 days of receipt of the information listed above or within 90 days of any additional information requested by AHCCCS.

C. Payments and/or recoupments as a result of the annual reconciliation process will be paid or recouped from the next regularly scheduled quarterly supplemental payment unless the next scheduled payment is subsequent to December 31st. If the next scheduled payment is subsequent to December 31st, then AHCCCS will process a separate payment or invoice to ensure all payments and recoupments are processed by December 31st. **The quarterly supplemental payments will be withheld if the annual reconciliation data requested is not received by AHCCCS by June 30th .** (EXAMPLE: For the federal fiscal year ending September 30, 2006, data requests will be sent out by AHCCCS no later than January 30th 2007, data is due from the FQHCs/RHCs no later than June 30th 2007 and all annual reconciliation payments/recoupments must be completed by December 31st 2007.) Quarterly Supplemental Payments

1. AHCCCS Contractors are required to submit FQHC/RHC member month and reimbursement information for Title XIX members assigned to FQHCs/RHCs on a calendar quarter basis to AHCCCS' Division of Health Care Management within 60 days of the end of the reporting quarter. To be counted as a member month the member must be enrolled as of the first day of the month. AHCCCS will review the information for reasonableness based on historic FQHC/RHC enrollment, and calculate the quarterly supplemental payment amount. A Remittance Advice Form (See Attachment 2) will be sent to the FQHCs/RHCs advising them of the number of member months reported by the MCEs and the calculation of the quarterly supplemental payment amount. If there are any discrepancies between the FQHC and MCEs' member month totals, refer to section V. of this policy.

2. AHCCCS will process the payment request on the 20th day of the month for a payment on the last business day of the month following receipt of the quarterly reports (i.e. March, June, September and December) from the MCEs. Payments may be offset by any credit balances in the AHCCCS accounting system, amounts due AHCCCS as a result of the annual reconciliation, or any amounts being withheld from the FQHC/RHC for non-compliance with this policy. The Medicaid Manual prohibits payment for services in advance. All payments are processed in a batch following draw down of federal funds, therefore, AHCCCS cannot process individual payments.

IV. Timeliness, Accuracy and Completeness

The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report and AHCCCS may withhold future quarterly supplemental payments. Standards applied for determining adequacy of required reports are as follows:

A. Timeliness: Reports or other required data are received complete and accurate on or before scheduled due dates.
B. Accuracy: Reports or other required data are prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
C. Completeness: All required information is fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

V. Adjustments to FQHC/RHC Reports

Adjustment for a Previous Quarter

1. If an FQHC/RHC has any questions about the member months reported by a MCE, they must contact the MCE directly to answer any questions or resolve any discrepancies in member month information. An FQHC/RHC can sign the Remittance Advice form and be paid for all member months except those in question.

2. AHCCCS may make payments to FQHCs/RHCs for Title XIX member months from a previous quarter. FQHCs/RHCs are limited to the two previous quarters for additional payments due to adjustments. All adjustments that would reduce the payment must be submitted regardless of the length of time.

3. An explanation from the MCE or the FQHC/RHC for the adjustment must be submitted along with the revised reports to AHCCCS before a payment related to a previous quarter will be made to the FQHC/RHC.

4. Once the discrepancy has been resolved, the MCE must resubmit the member months for that FQHC/RHC and an adjusted remittance advice will be sent to the FQHC/RHC for their review and signature. The adjustment will be reflected in the next regularly scheduled supplemental payment.

VI. Additional FQHC/RHC Responsibilities

A. It is the responsibility of the FQHC/RHC to review in detail, by the requested due dates, the quarterly and annual reconciliations to ensure the correctness of the data provided and immediately report any discrepancies for appropriate action. This responsibility includes verifying the member months reported by the MCEs to AHCCCS on a quarterly basis.

B. The FQHC/RHC shall monitor, at least on a quarterly basis, the estimated receivable or payable that may result from the annual reconciliation process to ensure the FQHC/RHC is appropriately managing cash flow for any potential payments due AHCCCS.

VII. References

- Acute Care Contract, *Section D, Paragraph 34, FQHCs/RHCs*
- ALTCS Contract – *Section D, Paragraph 42, FQHCs/RHCs*
- Benefits Improvement and Protection Act of 2000 *(BIPA)*
- State Plan Amendment (SPA) 03-007